STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001145	A. BUILDING: _____ B. WING _____	C 04/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBERT E LEE	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00171596. Complaint IN00171596 - Substantiated. No deficiencies related to the allegations are cited. Survey date: 4/24/14 Facility number: 001145 Provider number: 155616 AIM number: 200120200 Census bed type: Residential: 12 Total: 12 Census payor type: Medicaid: 6 Other: 6 Total: 12 Residential Sample: 4 Robert E Lee was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00171596.	R 000		